

S. No. 2  
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5-17-39  
PI X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. 29396  
Registrar's No. 8092

FILED SEP 8 1947  
Registration District No. 318

Primary Registration District No. ....

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County .....  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Deconess Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... (Specify whether  
In this community..... (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 000  
(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1363 Graham Street 9  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Frank W. Peistrup  
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Male 5. Color or race white  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Hulda Peistrup  
6. (c) Age of husband or wife if alive 44 years  
7. Birth date of deceased February 17 1900  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
47 6 6 hr. min.

9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Book-keeper

11. Industry or business Dolan Real-Estate

MOTHER FATHER

12. Name Frank L. Peistrup

13. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Bemis

15. Birthplace Clayton Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Hulda Peistrup

(b) Address 1363 Graham Street

17. (a) Burial (b) Date thereof 8/27/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Resurrection Cem.

18. (a) Signature of funeral director [Signature]

(b) Address 7146 Manchester Ave.

19. (a) AUG 26 1947 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 23rd  
year 1947 hour 9 minute 45 P.M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;  
that I last saw him alive on....., 19.....;  
and that death occurred on the date and hour stated above.

Immediate cause of death Edema of Brain  
Arteriosclerotic Hypertrophy  
Heart Enlargement  
Due to.....

Due to.....  
Other conditions (Include pregnancy within 3 months of death) 95

Major findings: Of operations.....  
Of autopsy.....  
PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify).....  
(b) Date of occurrence.....  
(c) Where did injury occur?..... (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature [Signature] (Specify type of place) While at work?..... (c) Means of injury.....  
Address..... Date signed 9/2/47

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Elmo R. Padwell  
Licensed Embalmer No. 4077

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**